Intimate Partner Violence and VHA Medical Care

Megan Gerber, MD, MPH
Medical Director, Women’s Health
VA Boston Healthcare System
Acknowledgements

• The women Veterans whom we have the honor to serve.

• Thank you for teaching us about strength, resilience and recovery.
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Goals/Objectives

• Review the basic epidemiology of Intimate Partner Violence (IPV).
• Understand what is known to date about women Veterans and IPV and understand challenges/opportunities for VA care delivery.
• Learn approaches to responding to IPV in primary care.
• Consider ways in which PACT providers and health services researchers may contribute to improving the care of Veterans impacted by IPV.
Poll #1

• What is your role within the VA?
  - PCP
  - Mental Health Provider
  - Other Medical Provider (Emergency, Specialty etc)
  - Nurse
  - Researcher
  - Women Veterans Program Manager
  - Administrative/Management Staff
  - Other
Definition and Background
CDC Definition

• The term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse.

• This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

Types of IPV

- **Physical violence**: the intentional use of physical force with the potential for causing death, disability, injury, or harm.
- **Sexual violence**: unwanted sexual activity (attempted or completed).
- **Emotional violence**: trauma to the victim caused by acts, threats of acts, or coercive tactics.
- **Stalking**: repeated behavior that causes victims to feel a high level of fear.

CDC. National Center for Injury Prevention and Control. [http://www.cdc.gov/ncipc](http://www.cdc.gov/ncipc)
Epidemiology

- National Intimate Partner and Sexual Violence Survey (NISVS) is the most recent population based study.
- Lifetime – 35.6%, Annual – 5.9%
- 7 Million women experience IPV annually.
- Same-sex couples understudied; rates may be up to 2x higher.
  - NVAWS 21.5% men and 35.4% women reported lifetime IPV.
  - Advocacy programs: steady increase in reports.

SES Risk Factors for IPV

- Younger age (highest 18-24).
- Income (all three major ethnic groups) especially for severe IPV.
- Unemployment.
- Black > Hispanic > White.
- ?gender preference

Other risk factors

• Antecedent IPV.
• IPV in family of origin.
• Experience of child abuse.
• Alcohol > drug use.
• Polysubstance use – increased risk.
• Depression.
• PTSD.

Herrenkohl 2007, Kuijpers 2012
Scope of the Problem for Veterans

• We are just starting to understand the true impact of IPV on the Veterans population.
  – Unique set of challenges
  – Early life circumstances
  – Military Life
  – Comorbid PTSD, Substance Abuse, TBI.
• HSR&D has funded two CDA: M. Dichter PhD, MSW and K. Iverson, PhD.
• VA Guidance forthcoming.
IPV is complex

• “Victimization” and “perpetration” infer mutually exclusive states.
• Dynamics of abusive relationships are complex; bidirectional violence is common and IPV may range from low level to severe.
• **Veteran who experiences violence:** A Veteran who is the recipient of violent behavior. Traditionally referred to as victim or survivor of intimate partner violence.
• **Veteran who uses violence:** A Veteran who uses violence toward his/her partner. Traditionally referred to as batterer, abuser, or perpetrator.
Poll #2

• Among clinicians attending today’s call, please indicate the % of your patient panel comprised of Women Veterans:

1 0%
2 5-10%
3 10-30%
4 > 30%
Gender Issues

• Women are more likely to sustain physical and psychological consequences from IPV.
  • IPV disproportionately affects women’s health.
  • Current research identifies women who experience IPV as the highest risk group.
  • When women use IPV, it tends to be lower severity.

• However, it can be difficult for men to disclose receipt of IPV.
  • NISVS lifetime experience of physical IPV: women (32.9%) and men (28.5%).
  • Older studies have shown lower rates in males.

• Use (“perpetration”) of IPV has health consequences of its own.

IPV and Military Personnel

- Rates range from 13.5-58%.
- Active duty personnel are at much higher risk of being perpetrators of IPV.
- PTSD incidence correlates with higher risk of IPV perpetration.

Women Veterans

• Higher rates of child abuse and pre-military trauma.
• 23-30% report IPV during active duty.
• Mental health: 70% lifetime rate of IPV.
• Primary Care
  – Of 91 patients 24-95, 46% reported current or past IPV.
  – Of 20 OIF/OEF veterans screened, 50% reported current or past IPV.
• BRFSS data: ⅓ veterans experience lifetime IPV compared to < ¼ non-veterans.
• IPV associated with increased odds of heart health risks.

Campbell et al, 2003; Sadler et al, 2004; O’Campo et al, 2006; Iverson (National Center for PTSD); Latta and Ngo (unpublished, VA Bedford); Dichter et al, 2011.
OEF/OIF Veterans

- Data is limited to date.
- Study of recently returned veterans screened in primary care (recently separated at < 2 years):
  - 75% reported family readjustment issues.
  - 60% reported any IPV; however, the researchers’ definition included “shouting” so this may be an overestimate.
  - No difference in rates by branch of service.
  - ¼ reported guns in the home.

Health Impact of IPV
IPV in Medical Practice

Primary Care Prevalence:
• 12-month 5.5-14%
• Lifetime 21-60%

Ob/Gyn Prevalence:
• 12 month 4-15%
• Lifetime 35%
• During pregnancy 6-20%

Emergency Department Prevalence:
• 12 month 11-19%
• Lifetime 11-54%
IPV is a Medical Issue!

• In a multi-city study of femicides, 41% had been in contact with a health care provider prior to death, while only 3% accessed an advocacy or shelter program.

• You are in routine contact with affected patients!

• However… while nearly 50% of women who experience physical IPV report being injured by the abuse, only 20% actually seek medical care for their injuries

Physical Health Effects

• Linked to increased incidence of:
  – Headaches
  – Pelvic pain
  – Abdominal pain
  – Chest pain/palpitations
  – Gastrointestinal problems/IBS
  – Chronic pain/Fibromyalgia
  – Medically unexplained symptoms

• Your patient with the “list” may be in a relationship impacted by IPV!
Reproductive Health

• Women who report abuse are more likely to have:
  – STI/PID.
  – Repeat vaginal or urinary tract infections.
  – Unwanted pregnancies.
  – Premenstrual symptoms: mood swings, irritability, etc.
  – Adverse pregnancy outcomes
    • Low birth weight.
    • Pre-term labor.
  – Miscarriage in prior 6 mos.

IPV and Pregnancy

• Women at higher risk of experiencing IPV during pregnancy
• Changes in type of IPV (i.e., from emotional abuse to physical abuse)
• IPV is leading cause of maternal mortality and adverse maternal outcomes in the U.S.
• Increasing recognition of women’s use of IPV during pregnancy.

Chambliss LR, 2008, Hellmuth 2012
Mental Health and IPV

- PTSD
- Depression
- Anxiety
- Substance abuse
- Suicidality
**IPV and Adverse Health Behaviors**

- Women who smoke are 2x as likely to report IPV.
- Women who experience IPV are 5x as likely to engage in problem drinking
  - It has been argued that alcohol and substance misuse increase IPV risk.
  - But alcohol and substance use have been shown to increase from a baseline level when new abuse occurs.
- Predicted probability of IPV is higher with alcohol use and even higher when the patient smokes and drinks.

Long-Term Health Effects

• A relationship exists between severity of abuse and degree of physical health problems.
• Even women who have experienced psychological abuse and/or low level abuse report significantly increased physical health symptoms.
• Many chronic diseases more prevalent or more severe.
Abusive Relationship Dynamics

- Women can experience IPV in the absence of physical violence.
- Women experiencing IPV are often isolated.
- Partners can interfere with receipt of healthcare.
- Poorly compliant patients may be suffering abuse.
- A controlling partner may refuse to leave the room.
Patients with a “list” may have abuse histories…

• Greater abuse severity and exposure to multiple forms of abuse is associated with more physical symptoms

• Women experiencing ongoing IPV report more somatic symptoms over time

Healthcare Response
Poll #3

• How comfortable do you feel addressing IPV in your VA role?
  - Very uncomfortable
  - Uncomfortable
  - I can do it if I have to
  - Comfortable
  - Very comfortable
PACT and IPV

- Complex issue that no single provider can ‘manage’ or fix.
- Patient preferences/needs of family critical.
- Requires knowledge of community and VA resources.
- Patients experiencing IPV…
  - Are often isolated from social networks.
  - Ashamed of the abuse.
  - In poor health.
  - In need of a team approach.
Patient’s Voices

I asked my patients the following question:

“What would you like your VA provider to know about intimate partner violence and the abuse you’ve experienced?”
• Patient came to Boston with children to escape an abusive partner. He doesn’t know where she is. She is living in a shelter and hopes to start a new life here. She has diabetes and recently started insulin.

• “You’re looking at me now, your body is turned toward me. I feel safe with you.”
Patients expectations…

- A meta-analysis of studies looking at women’s expectations of clinicians also found that women wanted clinicians to:
  - Be non-judgmental and individualized.
  - Not pressure the victim to talk about abuse, or pressure her to leave the situation.
  - Not pressure her to prosecute the abuser.

*Women want you to understand the complexity of a violent relationship and to meet them where they are in the continuum of deciding what to do.*

Can We Help?

• Qualitative studies demonstrate that abused women want their providers to query them about IPV.
• Studies also show that abused women believe medical providers can help.
• **Asking is an intervention.**
• Frame IPV as part of SH, an adverse health exposure.
Common Clinician Barriers

• Fear of opening “Pandora’s box.”
  – Time constraints
• “I don’t know what to do if she says yes.”
• “I can’t fix it.”
  – No quick fix
• Does not follow traditional biomedical model.
  – VA care models ideal for complex issues!
Addressing Barriers

• It’s not your role to “fix it.”

• You can:
  – Provide support and validation
  – Offer education and resources, referrals
  – Address safety
  – Document and treat injuries

• Adopt a patient-centered team approach; use existing VA resources.
Benefits of Routine Inquiry

• Communicates that you believe this is a health issue for patient ("bringing it into the exam room")

• Over time, you will become more comfortable talking about IPV.

• Hopefully, as the patient comes to trust you, she may disclose experience of violence.
How To Identify IPV?

• Directly inquire about IPV
  – Many individuals will not spontaneously disclose abuse.
  – When asked directly, many patients are willing to discuss IPV.
• Asking = intervention and begins a process.
• Assessment validates abuse as a legitimate health care issue and enables teams to assist.
• Primary care/PACT ideal for building trust/extending support.
Screening for IPV

• USPSTF
  – Recommends that clinicians screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to intervention services (level B)

• Reasons to screen include:
  – High prevalence
  – Decreases stigma by normalizing discussion of violence
  – Potential to moderately reduce exposure to abuse, physical and emotional injury, and mortality (USPSTF).

*VA guidelines are forthcoming.

Best practice for asking about IPV?

• Develop your own routine for asking that makes it comfortable for you
• Introduce the questions:
  – “Because violence in relationships is so common, I have begun asking all my patients about it”
• Consider assessing for both current and lifetime IPV.
• Short validated screens exist.
Examples of questions

• Ask behaviorally specific questions, such as:
  – “Have you been physically harmed or threatened by your partner?”
  – “Have you been hit, kicked, punched, choked, or otherwise hurt by an intimate partner?”
  – “Do you (or did you ever) feel controlled or isolated by your partner?”
  – “Do you feel frightened by what your partner says or does?”
  – “Has your partner ever forced you to have sex when you didn’t want to? Has your partner ever refused to practice safe sex?”
Setting and Timing for Inquiry

- Private setting – partner should be asked to leave the room.
- Family, friends, and children over the age of 3 should not be present.
- Get into a routine/combine with social history.
- When signs and symptoms raise concern (‘red flags’).
- During pregnancy.
Potential Clinical Markers for IPV

- Secrecy or obvious discomfort when asked about intimate relationships.
- Unexplained injuries or injuries that are inconsistent with the explanation of the injury.
- Medically unexplained symptoms (MUS).
- Chronic pain without apparent etiology.
- An unusually high number of health care visits.
- Tobacco and alcohol use.
Targeted Inquiry/Case Finding

• When injuries don’t fit the history given by the patient.
• Chronic pain, multiple somatic issues.
• Depression, anxiety, PTSD.
• ETOH or other drug abuse.
Patient Disclosure – Step 1

• Stop what you are doing.
• Turn away from the computer.
• Make eye contact.
• Respond with empathy and compassion.
• Validate what she is saying.

Always be ready for an affirmative response; often it will be a surprise, coming after recurrent denials.
Examples of “First Responses”

• I believe you. That must be a horrible experience.
• I’m sorry that you have to experience that. I would like to help.
• The abuse is not your fault. It is wrong for one person to hurt another person.
• You didn’t do anything to deserve to be treated this way.
• I am worried about your safety.
• I’m glad you told me. Let’s think about ways to get this behavior to stop.
• Unfortunately, you are not alone. Many of my patients have experienced abuse.
Patient Disclosure Step 2

• Your role now:
  – Non-judgmental, supportive, and concerned
  – Provide validation
  – Treat health problems and injuries
• Provide education/palm card.
• Evaluate whether patient is in immediate danger (use your team).
• Make referrals within the VA and for services in the community.
Risk Assessment

• Women may not realize they are in imminent danger
  – Over half of the victims of a completed or attempted homicide did not think that they were in danger.

• Danger increases if:
  – Abuser has access to weapons.
  – Abuser uses alcohol or other drugs.
  – There is past history of severe abuse (with serious injuries).
  – History of stalking.
  – Recent escalation of the abuse.
  – Unemployment.
  – Partner controls daily activities.

Campbell et al, 2002.
Documentation

- Document your assessment.
- Document in specific detail what the patient has told you – be specific; include name of perpetrator, specific instances, and timing.
- Document injuries and physical findings.
- Comply with state mandated reporting laws.
Your Patient Might Not Leave…

• It’s hard to leave a relationship.
• Info or kind words may help down the line.
• You haven’t failed if your patient doesn’t leave the relationship.
• Remember that survivors of IPV have lost their sense of agency and autonomy – support patient’s choices even if you don’t agree with them.
• *Never tell a patient impacted by IPV what to do.*
Be supportive

- Understand the barriers to each woman’s decision to leave or not and respect her decision. (Be patient-centered).
- Respect the victim’s timetable.
- Help the victim gain self-esteem by validating her actions, while at the same time being honest about your concern for her safety.
Next Steps

• If no immediate danger…
• If affected patient is not ready to leave the situation…

• Provide local resources:
  – Hotlines all states have these – may be used from your facility 1-800-799-SAFE.
  – VA Social work and mental health referrals.
  – Women Veterans Program Manager.
Children and Reporting

• Some states have mandatory reporting for IPV. The majority do not.
• Many women fear that their children will be placed in protective custody.
• What if there are children in the home?
  – You may need to report.
  – Social work consult is advisable.
Safety Planning

- Process similar to “harm reduction” strategy.
- Provides a back-up plan for any escalation of violence.
- Pack a bag and keep it in a safe place, copy important documents (DD214).
- Code word that friends, neighbors, or family will recognize to prompt them to call the police. Protection order information.
- Safety plan available from National Coalition Against Domestic Violence
  - YOUR TEAM CAN HELP.
What if My Patient Endorses Past IPV?

• Provide validation and education.
• Discuss the impact of past IPV on mental and physical health.
• Inquire about current mental health symptoms.
• Offer appropriate mental health referrals.
Helping Veterans Who Use Violence

• Screening issues
  – No good evidence for screening for use of IPV.
  – Targeted inquiry is warranted when patient shows signs of chronic pain, mental health issues, substance abuse.
  – Study of screening for perpetration showed low rates of disclosure with direct inquiry by PCP

• Interventions for use of violence/perpetration alone lack evidence of efficacy.
  - Treat co-morbid PTSD, substance abuse
  - Veterans with PTSD 2-3x more likely to perpetrate and interventions for this group show reductions in IPV.

• Self-identified perpetrators
  – Respond in non-judgmental manner that supports disclosure, and does not cut off further discussion, but also does not condone the behaviors
  – Refer to an expert in dealing with perpetrators.

Efficacy of Advocacy and Referrals

- Advocacy is very helpful to victims of IPV
- Research shows that patients who talk to their health care provider about IPV had higher likelihood of using an intervention (e.g. shelter, restraining order, IPV hotline)
  - Qualitative and RCT data.
- Our conversations and referrals do help!
National Hotlines and Helplines

• National IPV Hotline
  – 1-800-799-SAFE
  – English and Spanish (24 hr)

• National IPV website
  – ndvh.org
  – Resource list: www.ndvh.org/resources/

• National Center for PTSD:
  http://www ptsd va gov/public/pages/domestic-violence asp
Summary

- IPV is prevalent in medical populations and is a significant issue for Veterans.
- Some of your most vexing patients could be abused or have a history of abuse.
- You are in regular contact with patients who have experienced (used) IPV.
- Your patient care skills, PACT team and existing VA resources can help.
- With practice, addressing this issue becomes more routine.
What questions do you have?
Military/DoD Resources

• Military Home Front

• Family Advocacy Program (FAP) service providers
  – Search by military installation and program type online at http://www.militaryinstallations.dod.mil/
  – Every installation has a FAP or access to one.

• Battered Women’s Justice Project - Military Advocacy Resource Network

• Military OneSource
  – 1-800-342-9647, 24 hours a day, 7 days a week
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